

## The Committee of the Chiefs of Military Medical Services in NATO (COMEDS) and its Relation to RTO/HFM Panel

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### **COMEDS AND ITS RELATION TO RTO/HFM PANEL**

*In an attempt to look a few years ahead and sense what current and foreseeable developments in society, medicine and the military could mean for our profession as military medics, future challenges for military medical professionals are described.*

*Which role COMEDS play to facilitate the adaptation of our multinational military medical community to these evolutions and the support RTO-HFM Panel can give to COMEDS is developed.*

### **1.0 THE SECURITY CHALLENGES OF A PROFOUNDLY CHANGING POLITICO-MILITARY ENVIRONMENT.**

Over hardly a decade, the speed of change within our societies has increased dramatically.

Some of the most striking phenomena affect fundamentally, both as individuals and as societies, our perception of the hazards that may hamper our safety, well being and way of life.

One factor is the unprecedented globalisation and interdependence of human activity. This leads to increased mutual contacts and mobility of people, goods and ideas. People are well aware that lingering crises in remote parts of the world may indirectly affect supply lines of energy, stock markets, weather patterns, global economy and finally their jobs and families. But at the same time, it may directly confront them with terrorism, when taking their next business or holiday flight.

This evolution had already been accelerated by the media revolution. The so-called CNN factor became famous during the first Gulf war. What has been added to that is the incredible expansion of web accessible information and Email contacts over the last years. Today hundreds of millions of almost instantaneous individual information exchanges take place, without any state authority controlling this flow. This fact is an incredible factor of freedom, as well as an enormous risk factor. This is because the quality of the information can be quite poor and the mass magnitude of this medium can turn it into a real psycho shock wave, which is an identified prime terrorist goal. Let alone the so called "cyber attacks",

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which can virtually paralyse entire sectors of society. Defending against these hazards has become a multi billion business.

Add to this the fact that there is a diagnosed “democratic deficit” in an increasing number of inter- and multinational organisations. This phenomenon is exacerbated by the lack of accountability for decisions taken by multinationals and by the global networking of organised crime.

All these factors lead to a de facto decreasing influence by the individual States on the course of action in crucial domains, such as defence, finance, and even provision of welfare.

At the same time, this situation increases the likelihood that relatively small states, or non-state actors, organisations or groups of extremist use asymmetric means, in order to impose their political or financial aims on a global scale.

The sociological fact that aging western societies face growing immigration pressures, due to demographic evolutions, mainly in the south, fits in this anxiety model.

Sociologists predict increasing competition for shrinking natural resources, such as water and energy will boost instability in major parts of the globe. Even without further proliferation, some states in these regions are known to have weapons of mass destruction (WMD) today.

While conventional war will remain the means of last resort to resolve inter-state confrontations, the majority of future conflicts will be asymmetrical.

The rise of non-state threats is a tremendous problem for Western governments and militaries, because we are legally and behaviourally prepared to fight other legal-basis states. Furthermore, although the human suffering is the same, one could cynically say that personnel casualties within typical four member families have greater society impact than in societies with a traditional demographic overflow. The reluctance within our western type nations to cope with the inevitable casualties of conflict is a well-known weakness known worldwide. This makes terrorist or guerrilla type actions causing lots of casualties the more attractive for those who are technically in the underdog situation.

It obviously has made it crucial to “win the media war”. Media coverage now has a dramatic effect on public opinion, morale of troops and finally on political sustainability within world-wide coalitions.

## **2.0 HOW ABOUT NATO?**

NATO has spent decades in the so-called “Cold War era”. This period was characterised by the mutual nuclear deterrent and a vast geographical spread of numerous army divisions along a static border. The enemy was “doctrinally templatable” and Alliances were fixed. Nations had draft systems in place, so manpower was not a problem. Plans anticipated huge casualty rates in case of a major combat between these heavily armed and mechanised forces. The mutual nuclear deterrent, a predictable way to mutually assured destruction, worked.

Since the collapse of the former WARSAW Pact, which culminated in the fall of the BERLIN Wall and the whole Iron Curtain, the strategic environment has dramatically changed.

This period was followed by the NATO led operations in the BALKANS, which started in the early nineties and are still ongoing. This is the era of the Peace Support Operations. Its characteristics are quite different. After having agreed, or forced to agree by the multinational community to a peaceful end of a war situation, a multinational force separates belligerents. They gradually evolve under military presence and political guidance towards a peaceful cohabitation. These ongoing peace support operations continue, as a shared burden, whilst NATO Nations continue to downsize their post Cold War Forces and the Alliance will have expanded to twenty-six Nations.

Yet, a new historical trend has profoundly changed the transatlantic Alliance, since the nine-eleven terrorist attacks on the United States.

NATO was focussed on the state-centred threat and was not geared for non-state menaces.

In fact, the NATO summit in PRAGUE set out the new beacons for NATO in the new security environment. It stated ‘‘NATO needs the capability to field forces that can move quickly to wherever they are needed and sustain operations over great distance, including in an environment where they might be faced with biological, chemical and nuclear weapons.’’

This declaration ended the “out of area” debate in NATO. NATO is now involved in its first out of area operation in AFGHANISTAN.

Key evolutions within this new approach are the creation of the NATO Response Force, which is designed to operate in a high intensity environment. It will be kept at short notice, will be sustainable on its own for at least 30 days and will be able to draw on designated specialist capabilities, including a dedicated NBCR battalion.

A permanent matter of concern in NATO is the capability gap between the United States and its European Allies. This could lead to a “de facto” role for the US and coalitions of the willing in high intensity war fighting and a specialisation of European Nations in “mop-up operations”.

Indeed, the European Rapid Reaction Force is more oriented towards peace and stability operations around Europe.

### **3.0 THE CHANGING MILITARY IN NATIONS.**

Many European Allies are now underway in creating smaller, lighter, more mobile Forces, which are sustainable over longer periods.

The war in IRAQ showed us again the increasing use of remotely controlled precision weapons, and a dramatic evolution towards network-centric warfare techniques. It also shows us that despite a quick dismantling of the classical military means of the adversary, keeping the peace in regions where the population is traditionally armed, can pose a serious and costly challenge in both forces needed and casualties suffered.

The US Joint Forces Command and other NATO nations staffs currently develop new joint missions doctrines. These are meant to provide the services with a blueprint for joint missions in an age of unpredictable enemies and undefined battlefields. Major combat, stabilisation, homeland security and strategic deterrence are the main doctrinal components.

In the end, what matters most in war is what is in the mind of one's adversary. It is clear that the asymmetric warfare is one aspect emerging from the superpower unbalance in classical conflict. Modern western technology created the intelligent weapon. Ironically, this million-dollar weapon is also to strike pre-emptively to destroy or deter so-called "rogue states", but also terrorist groups of all kind.

These groups easily recruit amid thousands fanatic, frustrated and religiously determined young people. Once "loaded" with some explosives, they become cheap and deadly accurate "intelligent human bombs".

Our armed forces are faced with three pressures: falling defence budgets; rising costs of both equipment and personnel; and demands for more spending for increasing new roles and missions.

The transition in most Nations to an all- volunteer force has driven the manpower cost. Most armed forces have a massive shopping list for both new equipment and personnel, which far exceeds the available means. As a result, not all these requirements can be met and harsh choices are to be made.

For equipment, the choice might be cancellation or delays for new programmes and smaller orders. For military personnel, the result is usually over-stretch, longer periods away from home, shortages, and a greater willingness to substitute reserves and civilians.

Today, the individual casualty is a substantial loss for any deployed force.

One consequence is that the pressure to improve the so-called "tooth to tail" ratio will ever increase. The ratio was one to one during the Cold War.

As an example: it is currently 70% in favour of non-combat support and infrastructure functions in the US Defence budget.

It is precisely this trend to make logistics, medical and general infrastructure pay more within shrinking defence budgets that pushes these support functions to adopt ever "lighter" and more flexible solutions.

We also see the implementation of the civilian" just in time delivery" principle on military logistics. In civilian life, this has dramatically increased the number of trucks on our roads and decreased the number of warehouses. In transit visibility is now the main challenge for the operational manager. Thus the trend to reduce the "logistics footprint" in operations continues.

It is also the main driver behind options for outsourcing (example: third party logistics support) and off the shelf commercial solutions. So the "lean and mean" force, focussed mainly on the combatant core business of the future is coming up quickly.

Quite obviously this evolution pushes medical support further on the road of stabilising techniques and consequent early aero medical evacuation. Medical support installations providing the comprehensive package of specialist care in theatre will become ever more rare an asset. They will increasingly be found in modular and containerised task tailored formats on board of support ships or as host nation support facilities in adjacent countries.

In the civilian sector, rationalisation through automation is often the option. Ultimately the question of the replacement of some of the combat functions by remotely controlled drones and robots comes nearer.

## **4.0 THE CHANGING MEDICAL PROFESSION**

In civilian health care, ever more emphasis is put on preventive action in order to reduce morbidity as a whole. Great effort is performed to restore social functionality of the individual patient.

Budgetary pressure will continue to promote new techniques, which should produce more outpatient care and shorten hospitalisation periods.

A well-established emergency care system continues to enhance its responsiveness, even in remote areas. Helicopter evacuation and emergency intervention care teams bringing advanced trauma support techniques to the spot of the traffic accident are quite common standard in most of our Nations.

Telemedicine and teleconsulting techniques as well as medical data transmissions continue to develop. These means offer “off the shelf solutions” for situations where scarce medical staffs should be engaged in more cost-efficient ways.

Although considered as disparate and still inadequate by many, civilian authorities have recently made efforts to enhance the responsiveness of the civilian medical infrastructure in dealing with the potential consequences of WMD.

## **5.0 WHAT DOES IT ALL MEAN FOR THE MEDICAL SERVICES?**

The inevitable trend to do more with less is likely to continue. At the same time, the political leadership, public opinion, the operational commander and the individual soldier and his family expect nothing less than the top performance to reduce the number and the consequences of casualties. Ever more effective body armour reduces fatal casualty numbers but increases significantly the medical challenge to save the survivor’s limbs. As a result, a greater percentage of wounded may need longer hospitalisation and rehabilitation. The ratio of disabled veterans may well increase.

Senior medical staffs will have to continue to make the case for their function. This is to be done in an environment where budget constraints boost interservice competition and concurrence amongst functions.

Military decision-makers quite naturally tend to minimise health and medical support matters, especially in the planning phase of operations. Taking into account that casualties mean some degree of defeat or failure and medical support installations are a considerable logistical burden to move and support, operational planners generally tend to see things too optimistically.

A positive evolution is a better understanding within the military of the importance to take care of pre and post deployment health issues. Preventive and post deployment reconnaissance and screening can substantially reduce both the occurrence and consequences of deployment related health issues. The myth of the young, healthy, well-trained and invulnerable fighter has happily vanished in favour of a more prudent approach of preventive health and veteran issues.

Medical support concepts will have to focus ever more on supporting smaller, more mobile units, equipped with greater precision firepower. This might imply the need to push forward life saving techniques to smaller unit levels, especially in Special Forces type operations. It will speed up the debate

of which medical, paramedical and non-medical personnel should be trained and equipped to perform which medical life-saving acts in operational crises situations. Asymmetrical conflict situations means that medical installations, road and air ambulances may lose the theoretical Geneva Convention protection they might have had in interstate conflict.

In the new asymmetric environment, the current clear-cut line between military and civilian medical care will increasingly prove artificial. Press and interpreters accompanying troops, urban warfare in a chaotic civilian environment, guerrilla type suicide attacks on troops in such an environment. The co-ordination with NGO in the post-conflict environment. The potential for WMD type attacks on troops and civilians in a “mixed environment” and how a restriction of movement policy would affect the overall sanitary situation. All these situations need to be addressed within the broader civil-military dialogue.

Let's not forget the evolution to the use of Non Lethal Weapons. We look at laser blinding, high energy beam shocking, foam immobilising, psycho vapours or rash-provoking means. All these will not be lethal, but surely will have some strong “incapacitating” medical effect. This means that medical specialised surveillance and care for the users and for those incapacitated will be needed. If this trend continues, we might need the ophthalmologists, psychiatrists, dermatologists and others back. These are the specialists we are dismissing today in trying to further downscale our military medical services.

In the longer run, we will need to move towards common capabilities. The greater size medical support (such as role 3 field hospitals and strategic aero-medical evacuation) are certainly up for potential pooling of efforts; certainly if we want these facilities to be able to function in CBRN environments.

The ability to medically support troops in a CBRN operational environment is key to the overall credibility of WMD defence. The medical function should dispose of the staffing and means to handle this kind of challenge. Too often concepts and plans dismiss CBRN as a prevention, warning and decontamination problem. Whilst this may be true for the CRN aspect, Bio defence will not be credible without capable medical support.

All this enhances the need for sound medical staffing and the profile of medical advisors within our organisations. Unfortunately, there is currently no consensus amongst nations about where to fit adequately the medical function within multinational staff structures and at which level it should be allowed to sit at decision-makers tables. It is clear that the new type of operations will increase the need for direct near real time web-centric co-ordination between the operational manager and the combat medical support elements at all levels.

## 6.0 WHICH ARE THE MEDICAL PLANNING PARAMETERS NEEDED?

For more than a decade, NATO and NATO nation's medical planners have used the medical planning parameters contained in the so-called ACE Directive 85-8. These generic casualty rates had been predominantly based on World War and Cold war statistical data. They were focussed on a deliberate presumption, which was the so-called 75 percentile. The choice was to generically plan for a medical support system which should be able to cope at all support levels with 75% of all historically known casualty data. This made it a robust planning tool for planning medical support for major mechanised combat operations. Its strength was the fact that NATO and NATO staffs had consensus on this approach and it also supported the force planning for robust medical support within nations. (Despite substantial erosion in recent years, we still draw today on these resources).

The need for an adaptation of these planning figures arose when NATO started the so called Peace Support Operations (PSO) in the BALKANS, which dealt with post conflict operations. Although the robust generic capacities were more than sufficient, justified criticisms mentioned the lack of fine-tuned figures and a capacity rather than a capability driven approach. In these days, the “small footprint” for logistics and the “zero casualty option” were the new benchmarks for all planners.

In fact, today's medical support should be predominantly driven by the capabilities needed to provide top level medical support to the individual casualty. So, the question of when at latest (so where?) should we be able to provide life and limb saving surgery becomes more important than the total number of beds we can deploy. Of course this approach points quite logically to more flexible and smaller units, rather to pushed forward quality than to mass capacity for big military battle support.

Currently, efforts are underway, mainly by the supreme Allied Command Transformation medical staffs and the COMEDS work group on structures, operations and procedures, to develop a new planning tool.

Nations collected data from the past decade operations should form a sound bases for a capability driven analyses and a consensus about a common planning tool. A broader understanding of the individual staff section's responsibilities in planning medical support should benefit to their credibility and Command support for the consequences of the findings. Once available, reliable NBCR planning factors should be added to the tool. In fact, one cannot currently plan for credible medical support, ignoring the possibility of NBCR consequence management.

## **7.0 NOW, WHAT IS COMEDS AND WHAT COULD IT CONTRIBUTE TO ADDRESS THESE NEW CHALLENGES?**

### **7.1 COMEDS, the history**

For more than two decades before the creation of COMEDS existed EUROMED, which was the forum for the Chiefs of Medical Services of the EUROGROUP (founded in November 1968). The value of such a forum was also recognised by the highest medical authorities of the US, CA and FR. The delegates of these Nations actively participated as observers in the work of EUROMED, together with the medical representatives of the Major NATO Commanders. So, even before its transfer to NATO, EUROMED had already become an unofficial authority on military medical matters in NATO. It was meant as a forum to promote mutual understanding, co-ordination of operational principles and procedures and exchange of medical information between the member medical services.

Although initially EUROGROUP Ministers had agreed in Dec 92 to the transfer of all EUROGROUP activities to the Western European Union, it was subsequently decided on 22 May 92 to make EUROMED available to NATO as the most appropriate medical umbrella organisation.

The MC approved on 22 Oct 93 with MC 335(military Decision) the establishment of COMEDS including Terms of Reference and the Council noted that on 6 Dec 93.

### **7.2 COMEDS, the structure**

As you know, today COMEDS represents the Nations and NATO medical communities at the most senior level. It is composed of the 19 Surgeon Generals, both Strategic Commands medical advisors and the IMS medical staff officer. The West European Union medical staff officer, the Military Agency for Standardisation and the Civil Emergency Planning Directorate Joint Medical Committee attend as non-

voting observers. Belgium provides the chairman, the staff officer and the secretary for COMEDS work from their national positions. The secretariat is located in the infrastructure of the Belgian Chief of Defence Staff. COMEDS has no budget; it has a liaison desk at the NATO International Military Staff.

COMEDS meets in plenary meetings twice a year (spring and autumn meeting at NATO HQ).

It has 9 specialised working groups, chaired by a Nation. These WG normally meet once a year (only MMSOP meets twice a year).

These working groups are the following:

- WG on dental service (DS) : chaired by GERMANY
- WG on emergency medicine (EM): chaired by ITALY
- WG on food hygiene and food technology (FHTVS): chaired by GREECE
- WG on medical materiel and military pharmacy (MMMP): chaired by UK
- WG on military medical structures, operations and procedures (MMSOP): chaired by GERMANY
- WG on military psychiatry (MP): chaired by UK
- WG on military preventive medicine (MPM): chaired by US
- WG on medical training (MT) : chaired by DK
- Standing group of partner medical experts: chaired by IRELAND

COMEDS is the Senior Committee responsible for co-ordination of military medical matters in NATO. Its direct reporting to the Military Committee symbolises the direct access of the medical advisor to the Commander at all times and at all levels. The reason for this sound principal is the sensitivity of the very specific, human resources related activities, and the medical communities are responsible for. This specificity does not interfere with the fact that, in NATO, medical is part of the broad definition of logistics and its activities should always be closely harmonised within the logistics family as well, of course.

I think we all realise that the ever expanding and multi-faceted challenge and risk environment our troops are confronted with can only enhance the need for sound medical advice to the Commander at all levels and well prepared, capable and flexible medical support to the men in the field.

COMEDS and the NATO Agency for Standardisation are currently underway in developing a new architecture for the military medical working groups. When accepted by the Military Committee, this new structure should increase effectiveness and transparency and allow a more streamlined management of activities.

### **7.3 Co-ordination within the medical community**

The fact that the Medical Advisors of both Allied Command Transformation and Allied Command Operations and the International Military Staff medical staff officer participate as full members in the COMEDS plenaries, guarantees the best circumstances for coherent consensus building and decision making at the policy making, doctrinal and conceptual levels. The sound principles of multinational medical support, coherently embedded within the broad logistics policies, have been created over the last years. Both Military Committee 326/2 and Allied Joint Publication 4-10 form the cornerstones of multinational medical planning, accepted by the Nations and NATO. COMEDS receives liaison reports from NATO Standardisation Agency and the Senior Civil Emergency Planning Committee/Joint Medical Committee. The COMEDS chairman reports to the Military Committee and provides a liaison report to the Senior NATO Logistics Conference.

## **7.4 COMEDS, the way ahead**

Facing shrinking defence budgets and manpower ceilings, many NATO Nations tend to progressively transfer manpower from combat service support functions, including medical, to combat and combat support functions.

Nations last decades Crises Response Operations experiences, fortunately, confirm the impression that recent casualty rates are strikingly low, although local mass casualty situations can never be excluded.

Disease and non-operational injuries (like traffic accidents) form the bulk of today's operational medical workload.

As a result, peacetime standards of timely evacuation and adequate treatment of the individual casualty govern the number and locations of medical installations deployed and the evacuation means needed.

This « new » situation increasingly drives Nations tendency to rely more heavily on reserve forces with lower readiness status for the Art 5 situations. The scarce remaining active duty units cover the minimum needs to support CRO contributions.

The scarceness of medical personnel has now become the driving factor to speed up the multinational integration of medical support structures.

In fact, the scarce, highly qualified and difficult to recruit medical personnel is facing more and more frequent operational tours of duty, interfering with their normal high workload in peacetime hospitals. In most cases they must experience the frustrating situation of technical underemployment during their deployment tours.

On the other hand, we observe an increasing need for medical preventive actions, before, during and after deployment and the growing sensitivities of the troops and the public opinion for the long-term health hazards of the operational environment.

In the coming years, the inevitable trend « to do more with less » will continue. We should, however be aware of the trap. Greater efficiency due to multinational co-operation is a positive evolution, but should not become the national excuse to further erode national medical capabilities into real operational showstoppers.

NATO and Nations operational and medical planners must find the right balance between enhanced multinational effectiveness in the field, increased demands for preventive medicine and the paramount need to maintain sufficient national surge capabilities for combat operations. All these challenges will enhance the need to form capable, multinationally oriented medical advisors, technicians and planners.

## **8.0 HOW CAN RTO/HFM BE SUPPORTIVE IN OUR COMMON EFFORT**

Surgeon generals and senior medical advisors are responsible towards the highest military and political decision-maker. They increasingly have to co-ordinate multinational medical support policies. To be able to do that, they themselves need sound staffing and technical advise. These should be based on the best available scientific and operational data and state of the art techniques and principles.

Quite obviously, RTO/HFM should continue to play a key role in supporting this process, since it can provide coherent bases for operationally oriented research initiatives.

A few good examples are the following:

RTO/HFM could support efficiently the current effort of ACT medical branch in reviewing and updating casualty rates for combined joint operations. ACT has requested Nations to provide their epidemiological morbidity data and will produce outsource analyses of these data. The scientifically statistical results should form the bases of a new casualty-planning tool to replace the current ACE Directive 85-8 model.

Another example is the Canadian study you performed about EPINATO and disease surveillance. This work has been of great help for the COMEDS to clarify the way ahead in this crucial field.

Because COMEDS wanted to exclude overlapping activities, it decided a few years ago to disband its research workgroup. It has become increasingly clear that RTO/HFM has an important role to play in supporting the COMEDS scientifically and meet its scientific research-oriented needs.

## **9.0 CONCLUSION**

Our analysis showed that the medical community has already made considerable progress over the past years. The standardisation base for a more coherent multinational medical support structure is well on track. This structure should be flexibly based on national contingents as well as on multinational solutions.

However, reality learns, that when it comes to concrete force generation and force planning issues, despite encouraging individual examples, Nations generally show reluctance to put into practice what was previously agreed.

The reason is obvious. The scarce role 1 and 2 and 3 assets are, quite normally and in first priority, highly visible integrated parts of the national contingents. The real problem areas occur at Corps or Force levels, where multinational integration is the real challenge and visibility and national sensitivities are less predominant. Our political and military leaders have recently experienced how medical support can become the unexpected operational showstopper. It would be unfair to look at the Surgeon Generals, certainly if they lack the means and power to prevent that from happening. Often, personnel and budget caps drive the force generation process and medical is genuinely ignored, until the support gaps show. Medical units, although theoretically present, usually turn out to be costly and hard to sustain.

Time will show if our political and military masters had the vision to give us the means and flexibility we need to confront the new challenges with the appropriate medical responses the public expects from us.

A lot of question marks remain also and the need to answer them together, sooner rather than later. Within its Terms of Reference, COMEDS is certainly trying to push these matters to the highest decision making levels. But sound advises to the highest NATO authorities by COMEDS must rely on strong scientific based data. The RTO/HFM Panel is therefore one of COMEDS preferred partners.